MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 21, 2003
9:03 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment

MS. MENSCH: My name is Stephanie Mensch and I'll from Advamed, the advanced medical technology association. I would like to address the competitive bidding discussion. We have some policy positions on this as the manufacturers of medical devices and medical equipment that would be covered under the demonstration or the competitive bidding suggestion.

First, we have some materials, a policy position -- we're opposed to competitive bidding and I'll leave that for the staff to distribute to the commissioners. We oppose it for a number of reasons, but one, you believe that it is one form of getting away from administered pricing, but we believe that it is still government-administered pricing, especially the way the demonstrations are set up. We believe that it will require the establishment of a large infrastructure to manage it, and we think that it could conceivably, based on a study that we had done on the House provisions last year, it could add almost one-third more of bureaucratic structure to CMS now. I'll leave that report with you.

This is troublesome especially since CMS cannot implement the appeals procedures, provisions that were put into place by BIPA. They don't have the staff to do it, and the Administration is talking about cutting back. So not only will you be eliminating some appeals provisions that some of these beneficiaries may need to have in place in order to make sure that any movement forward into competitive bidding is fair, but that we don't know how this could be administered on a national level.

Another problem is that CMS, we believe that CMS's evaluation of the demo overstates savings and understates some of the problems with it. To give you an example, they only looked at eight products in two states, and of those eight products four products had problems that they would admit to in their report. That was internal nutrition, neurologic supplies, orthotic supplies, and oxygen, portable liquid oxygen.

The other issue is that they talk about how there might be a savings of 17 to 20 percent but they didn't mention that the bids for urologic supplies went so low that in the second round for Polk County they paid more than the DME fee schedule in that area for the urologic supplies in order to reinstate it so they could get the supplies to the beneficiaries.

One other issue is that right now under the DME fee schedule products compete on service and there is a service component even with some of the most common or discrete products that you can look at. Right now they compete on service. Under competitive bidding where low price is the goal they will only be competing on the price. We're very concerned that service, which includes maintenance, instructions to the beneficiary on how to use it effectively will disappear, and there's some proof of that in the two demonstration projects.

Finally, we think that based on the MSA size that was under

the House language there's some concerns that you may find yourself doing two things. One, putting some small businesses that are suppliers out of business, and also affecting minorities in a larger way than others under the program. For some products this could be a considerable affect on minorities.

So thank you. We'll leave some materials with the Commission staff.

MS. McILRATH: I'm Sharon McIlrath with the AMA. I'll be brief, and we can perhaps provide you with some additional information. I don't in anyway want to condone the system that's out there now. I just want to point out, Glenn, that if you do this legislatively as opposed to administratively it will be scored in the law and regulation section of the SGR so you'll still end up having a reduction across all physician fee, because so long as the drugs are included in the SGR, and they're growing five times as fast or they were '96 through 2001, as the physician services, they're already pulling the payments down. Once you put this into the SGR and it gets scored you'll essentially have the same effect as if you did it administratively and the budget neutrality was applied because of the change in the practice cost for administering the drug.

MS. FOSTER: My name is Sheila Foster and I'm with ASCO. Because of the extensive conversation about the Gallup data I felt compelled just to make a couple of brief comments.

One is that this data is collected according to very, very strict guidelines that are set out in regulation. Those have all been followed, and in fact you can see that in the Lewin report. Those regulations also determine how aberrant data is treated. We have met with CMS about a couple of the high values and have explained to them what we think accounts for those high values. We've be happy to talk with you further or share some of that information with you.

MR. HACKBARTH: Okay, thank you, all. We'll see you in April.

[Whereupon, at 11:53 a.m., the meeting was adjourned.]